Physician-Hospital Integration
Strategies to Increase Quality and Maximize the Bottom Line

Danielle Sreenivasan, Senior Manager
The Camden Group
September 24, 2014
Orthopedic Services: Where Are We Today?
Historical Growth Largely Driven by Joints…

Growth in Key Procedures for Musculoskeletal Care
2002 to 2011

Source: HCUP Nationwide Inpatient Sample (NIS) and The Advisory Board Company
…With Increases in Costs Outpacing Volume Growth

Growth of Cost, Stays for Spine & Joint Replacement
2008 to 2011, All-Payer

Spinal fusion costs growing at nearly twice the rate of inpatient stays

Source: HCUP Nationwide Inpatient Sample (NIS); Orthopedic Network News (ONN); and The Advisory Board Company

(1) 2012 data was not available, and only Q1 of 2013 data was available.

National Joint Replacement Implant Costs
Average Selling Price; 2008 to Q1 2013

Spinal fusion costs growing at nearly twice the rate of inpatient stays

Average Hospital Costs
Number of Discharges

Spinal fusion costs growing at nearly twice the rate of inpatient stays

Source: HCUP Nationwide Inpatient Sample (NIS); Orthopedic Network News (ONN); and The Advisory Board Company

(1) 2012 data was not available, and only Q1 of 2013 data was available.
Increased Demand for Orthopedics Will Continue

10-Year Orthopedic Volume Forecast

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>15 percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>28 percent</td>
</tr>
</tbody>
</table>

Factors Impacting Future Orthopedic Volume and Growth

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Co-Morbidities</th>
<th>Revisions and Replacements</th>
<th>Clinical Innovations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging population driving joint replacement volumes</td>
<td>Smoking, diabetes, obesity correlated with osteoarthritis</td>
<td>Expected increase in demand over next 20 years given higher patient longevity</td>
<td>Technology improvements driving utilization</td>
</tr>
<tr>
<td>Osteoarthritis affecting larger share of population</td>
<td>Increased prevalence of obesity in hip replacement patients complicates outcomes</td>
<td>“Weekend warriors” may require eventual replacements following arthroscopy</td>
<td>Minimally invasive surgical techniques key innovation</td>
</tr>
</tbody>
</table>

Source: The Advisory Board Inpatient and Outpatient Market Estimator tools
Growth Largely Concentrated in the Outpatient Setting

All-Payer Volume Growth Projections
2013 to 2018

Orthopedic Services

Spine Services

15.4% Outpatient 5.1% Inpatient

22.9% Outpatient (0.1%) Inpatient

Volume Growth Projections by Key Sub-Service Lines
2013 to 2018

Spine Injections & Blocks Sports Medicine Hand Joint Replacement Foot Fracture/Dislocation Treatment Other Surgical Spine Fusion Orthopedic Trauma Sports Medicine Medical Spine

-7% 157 Percent Expected five-year growth of outpatient joint replacements 169,000 Projected volume of outpatient joint replacements in 2018

Source: The Advisory Board Inpatient and Outpatient Market Estimator tools
Industry Update:
Key Trends Impacting the Orthopedics Landscape
Healthcare Today

Complex, Confounding, Challenging… and Definitely Changing
Expect limited stability
Accept change is difficult
Be nimble
Adapt to fluctuations
Healthcare Trends for 2014

- Economy
- Healthcare reform
- Employer trends
- Payer changes

**Triple Aim™**

- Population Health
- Experience of Care
- Per Capita Costs
Pyramid of Success

- Quaternary
- Tertiary
- Community Hospital
- Surgical Specialists
- Medical Specialists
- Primary Care
- Access Points (UCC, FQHCs, ED, Health Plans, Physician Offices, Retail Clinics, etc.)

### Defined Population

<table>
<thead>
<tr>
<th>Commercial</th>
<th>CMS</th>
<th>Dual Eligibles</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>Accountable care organization (&quot;ACO&quot;) – Medicare Shared Savings Program</td>
<td>HMO</td>
<td>HMO</td>
</tr>
<tr>
<td>PPO</td>
<td>Pioneer ACO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct to Employers</td>
<td>Medicare Advantage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Exchange</td>
<td>Bundled Payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundled Payment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- HMO
- PPO
- Direct to Employers
- Insurance Exchange
- Bundled Payment
- Accountable care organization ("ACO") – Medicare Shared Savings Program
- Pioneer ACO
- Medicare Advantage
- Bundled Payment
- HMO
- Fee-for-service
ACO responsible for:

- Clinical care management (clinical integration)
- Capture data for continuum of care
- Measure and monitor costs and quality

**Infrastructure (Provided or Contracted ACO Operations)**

- Information Technology
  - EMR, CPOE, PACS
  - Data warehouse
  - Reporting
  - HIE
  - Web portal

- Care Management
  - Hospitalists and Intensivists
  - Chief medical officer
  - Disease management
  - Clinical protocols
  - Advanced analytics and modeling
  - Call center
  - Utilization management
  - Knowledge management

- Health Network
  - Delivery network

- Financial/Payment Systems
Roadmap From Fee-for-Service to Fee-for-Value

**Destination:**

- **Hospitalist and Hospital-based Physicians**
- **Reduce Re-admissions**
- **Bundled Payment**
- **System-wide Care Management Restructuring**
- **Clinical Co-management**
- **Patient Centered Medical Home**
- **Transactions/Network Development**
- **ACO**
- **Population Health**

**Fee-for-Service**
- **Patient Safety and Throughput**
- **Physician Relationships/Leadership Development**

**Fee-for-Value**
# Quality Comparison Data

## Inpatient Complication Rate Comparison Summary

**Years 2010 to 2012**

### Hip Fracture Treatment

<table>
<thead>
<tr>
<th>Category</th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
<th>Hospital D</th>
<th>Hospital E</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Rate</td>
<td>20.88%</td>
<td>29.67%</td>
<td>23.62%</td>
<td>14.50%</td>
<td>33.70%</td>
<td>21.27%</td>
</tr>
<tr>
<td>Projected Rate</td>
<td>19.38%</td>
<td>24.57%</td>
<td>19.93%</td>
<td>19.80%</td>
<td>21.42%</td>
<td>21.23%</td>
</tr>
<tr>
<td>Difference</td>
<td>1.50%</td>
<td>5.10%</td>
<td>3.69%</td>
<td>-5.30%</td>
<td>12.28%</td>
<td>0.04%</td>
</tr>
<tr>
<td>Star Rating</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

### Hip Replacement

<table>
<thead>
<tr>
<th>Category</th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
<th>Hospital D</th>
<th>Hospital E</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Rate</td>
<td>8.97%</td>
<td>15.71%</td>
<td>17.65%</td>
<td>4.80%</td>
<td>22.31%</td>
<td>8.10%</td>
</tr>
<tr>
<td>Projected Rate</td>
<td>9.93%</td>
<td>9.86%</td>
<td>8.86%</td>
<td>7.80%</td>
<td>10.23%</td>
<td>8.16%</td>
</tr>
<tr>
<td>Difference</td>
<td>-0.96%</td>
<td>5.85%</td>
<td>8.79%</td>
<td>-3.00%</td>
<td>12.08%</td>
<td>-0.06%</td>
</tr>
<tr>
<td>Star Rating</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

### Total Knee Replacement

<table>
<thead>
<tr>
<th>Category</th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
<th>Hospital D</th>
<th>Hospital E</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Rate</td>
<td>9.63%</td>
<td>14.93%</td>
<td>13.66%</td>
<td>6.15%</td>
<td>18.49%</td>
<td>7.76%</td>
</tr>
<tr>
<td>Projected Rate</td>
<td>8.51%</td>
<td>8.90%</td>
<td>8.03%</td>
<td>7.87%</td>
<td>8.62%</td>
<td>7.78%</td>
</tr>
<tr>
<td>Difference</td>
<td>1.12%</td>
<td>6.03%</td>
<td>5.63%</td>
<td>-1.72%</td>
<td>9.87%</td>
<td>-0.02%</td>
</tr>
<tr>
<td>Star Rating</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: Healthgrades

(1) Lower actual rates are better.

Note: Healthgrades used MedPAR database for years 2010 through 2012. Healthgrades evaluates hospital quality for procedures and treatments based on complications (if patients had problems as a result of their procedure or treatment).

- Green square indicates actual performance was better than predicted and the difference was statistically significant.
- Blue square indicates actual performance was not statistically significantly different from what was predicted.
- Red square indicates actual performance was worse than predicted and the difference was statistically significant.
# The Payer/Employer View of Orthopedic Providers

## Variation in Total Knee Replacement Commercial Payments

### Total Knee Replacement

**Average Blue Cross and Blue Shield Payment Per Case**

**(50 Mile Radius)**

**July 2012 to June 2013**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Average Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>$48,267</td>
</tr>
<tr>
<td>Hospital B</td>
<td>$46,259</td>
</tr>
<tr>
<td>Hospital C</td>
<td>$42,871</td>
</tr>
<tr>
<td>Hospital D</td>
<td>$36,415</td>
</tr>
<tr>
<td>Hospital E</td>
<td>$35,830</td>
</tr>
<tr>
<td>Hospital F</td>
<td>$34,904</td>
</tr>
<tr>
<td>Hospital G</td>
<td>$34,386</td>
</tr>
<tr>
<td>Hospital H</td>
<td>$33,261</td>
</tr>
<tr>
<td>Hospital I</td>
<td>$29,656</td>
</tr>
<tr>
<td>Hospital J</td>
<td>$29,436</td>
</tr>
<tr>
<td>Hospital K</td>
<td>$28,905</td>
</tr>
<tr>
<td>Hospital L</td>
<td>$27,906</td>
</tr>
<tr>
<td>Hospital M</td>
<td>$27,132</td>
</tr>
<tr>
<td>Hospital N</td>
<td>$27,002</td>
</tr>
<tr>
<td>Hospital O</td>
<td>$26,073</td>
</tr>
<tr>
<td>Hospital P</td>
<td>$25,822</td>
</tr>
<tr>
<td>Hospital Q</td>
<td>$25,333</td>
</tr>
<tr>
<td>Hospital R</td>
<td>$22,696</td>
</tr>
<tr>
<td>Hospital S</td>
<td>$22,261</td>
</tr>
<tr>
<td>Hospital T</td>
<td>$17,590</td>
</tr>
<tr>
<td>Hospital U</td>
<td>$10,810</td>
</tr>
</tbody>
</table>

Source: Blue Cross Blue Shield Association (Blue Health Intelligence)

Note: Includes all facilities that reported five or more cases for the period.
Includes all inpatient, physician, and ancillary services furnished during the period.
Key Trends Impacting Orthopedic Service Lines

- Increased adoption of minimally-invasive techniques and robotic-assisted surgery have resulted in lower average length-of-stays for joint replacement procedures. (2 to 3 days.)
- Value-based reimbursement and healthcare consumerism trends will shift market share to highly subspecialized orthopedic surgery practices.
- CMS and commercial payers have signaled that they are exploring policy changes to allow reimbursement for outpatient total joint replacement. (Will result in significant care delivery and financial performance changes.)
- Partnerships with post-acute providers (i.e., skilled nursing, home health, rehabilitation) are required to reduce related readmissions.
Key Trends Impacting Orthopedic Service Lines

- Payer arrangements (e.g., tiered benefits, direct-to-employer arrangements, narrow networks, bundled payments) will play a bigger role in patient referrals in the future.

- Expanding referral sources beyond traditional referrers (i.e., primary care physicians) will increasingly drive orthopedic service line market share.
  
  - Other referral sources could include emergency departments, chiropractors, podiatrists, sports teams, rehabilitation centers, and health plan narrow networks.

- Physicians will continue to play a critical role in remaking the healthcare delivery system into a value-driven one; robust and transparent data reporting will be essential to effective clinical decision-making.
Physician-Hospital Alignment Strategies
Why Pursue Physician-Hospital Partnership Strategies?
As a Means for the Hospital and Physicians to be the Providers of Choice and to Further Develop Value

<table>
<thead>
<tr>
<th>Market</th>
<th>Clinical and Quality</th>
<th>Operational</th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase physician involvement in the</td>
<td>Improve access to a wide range of health services to the</td>
<td>Improve coordination and efficiency of the</td>
<td>Align incentives between the hospital and</td>
</tr>
<tr>
<td>management and strategic direction of</td>
<td>community</td>
<td>management and operation of the orthopedic</td>
<td>physicians</td>
</tr>
<tr>
<td>service lines</td>
<td></td>
<td>service line</td>
<td></td>
</tr>
<tr>
<td>Meet the needs of the community</td>
<td>Increase patient satisfaction</td>
<td>Secure and improve the relationship between</td>
<td>Protect capital and other significant</td>
</tr>
<tr>
<td>Rapidly attract new services and</td>
<td>Fundamentally improve patient care and clinical outcomes</td>
<td>hospital and physicians</td>
<td>financial investments or commitments</td>
</tr>
<tr>
<td>technology to the market for the</td>
<td>Proactively define long-term relationship between the</td>
<td>Create operational efficiencies and decrease</td>
<td>Means to cope with reduced physician</td>
</tr>
<tr>
<td>benefit of the community</td>
<td>hospital and key physicians</td>
<td>costs of care where possible</td>
<td>income related to professional fees and in-</td>
</tr>
<tr>
<td>Mitigate areas of hospital and</td>
<td></td>
<td></td>
<td>office ancillaries</td>
</tr>
<tr>
<td>physician conflict and competition</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Align incentives between the hospital and physicians
- Protect capital and other significant financial investments or commitments
- Means to cope with reduced physician income related to professional fees and in-office ancillaries
Physician Alignment Options for Hospitals Fall Along a Continuum

<table>
<thead>
<tr>
<th>Physician Liaison</th>
<th>Recruitment</th>
<th>Non-compete Agreement</th>
<th>Provider Sponsored Clinics</th>
<th>Co-Management Agreements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Advisory Councils</td>
<td>Joint Marketing</td>
<td>Gainsharing Agreement</td>
<td>Real Estate/Medical Office Building</td>
<td>Select Employment</td>
</tr>
<tr>
<td>Medical Directorships</td>
<td>Management Services Organization Services</td>
<td>Management Services Organization Services</td>
<td>Information Technology Integration</td>
<td>Equity Joint Ventures</td>
</tr>
<tr>
<td></td>
<td>Bundled Payment Agreements</td>
<td></td>
<td></td>
<td>Federal Trade Commission Clinical Integration</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

New Stark Laws effective October 1, 2009 eliminates the ability of physicians to perform hospital services “under arrangements,” lease space or equipment to hospitals on a “per click” basis.
Strategies We Will Focus on Today

- Bundled payment arrangements
- Co-management agreements
What is a Bundled Payment?

A Bundled Payment is the process of making a single payment for all the care and services for a specific procedure or Episode of Care.
Bundled Payments: Nothing New Conceptually

- Medicare participating Heart Bypass Demonstration
- Medicare participating Centers of Excellence Demonstration
- Medicare participating Cardiovascular and Orthopedic Centers of Excellence Demonstration
- Medicare participating Cardiovascular and Orthopedic Centers of Excellence Demonstration
- Geisinger Health System
- Prometheus Payment Method
- CMS Medicare Heath Care Quality Demonstration Project
- ACE Demonstration “Value-based Care Centers”
- IHA CA Commercial Bundled Payment Project
- United Healthcare Oncology Bundled Payment
- Blue Cross New Jersey Orthopedics Bundled Payment
- Bundled Payments for Care Improvement Initiative
- CMS National Voluntary Pilot
Where Are Bundled Payments Happening?

Medicare, Medicaid, Commercial, and Employer Participants

- **Medicare Bundled Payments for Care Improvement**
- **Medicaid Bundled Payment Programs**
  - Arkansas
  - Ohio
  - Tennessee
- **Employer Bundled Payment Programs**
- **Commercial Bundled Payment Programs**

Source: Center for Medicare & Medicaid Services - June 2014; KEY PAYER AND PROVIDER OPERATIONAL STEPS to Successfully Implement Bundled Payments - May 28, 2014; Advisory Board, The Camden Group
What is a Bundled Payment Episode Composed of?

- Each bundled episode is composed of a set of Medicare Severity-Diagnosis Related Groups associated with a group of diagnosis codes.
- All Part A and Part B services associated with an inpatient hospital episode.

Includes costs for:
- Inpatient hospital fee
- Proceduralist fees
- Supplies/Implants/Devices
- Radiology
- Anesthesia
- Lab/Pathology
- Prescription drugs
- All other services related to the inpatient stay

(1) Up to 30-, 60-, or 90-days post-discharge (depending on model)
(2) Model 2 only
Greatest Opportunity to Bend the Cost Curve

Estimated Cumulative Percentage Changes in National Healthcare Expenditures, 2010 through 2019

- Bundled payment: -5.40% to 0.10%
- Hospital-rate regulation: -2.00% to 0.80%
- HIT: -1.50% to 1.00%
- Disease management: -1.30% to 0.40%
- Medical Homes: -1.20% to 0.30%
- Retail clinics: -0.60% to 0.20%
- NP-PA scope of practice: -0.50% to 0.00%
- Benefit design: -0.30% to 0.00%

Building on the CMS Acute Care Episode

Medicare Acute Care Episode Demonstration

- 3-year demo launched in 2009
- Medicare Part A and B payments bundled and discounted for 28 cardiac and 9 ortho diagnosis-related groups
- Gainsharing bonus potential for physicians not to exceed 25 percent of Part B payments

**Exempla St. Joseph’s Hospital**
- 565-bed hospital
- Cardiac only launched November 1, 2010

**Lovelace Medical Center**
- 218-bed hospital
- Ortho only launched November 1, 2010

**Hillcrest Medical Center**
- 727-bed hospital
- Cardiac and Ortho launched May 1, 2009

**Oklahoma Heart Hospital**
- 78-bed physician-owned specialty hospital
- Cardiac only launched January 1, 2010

**Vanguard Baptist Health System**
- Health system with 5 hospitals
- Cardiac and ortho launched June 1, 2009
“Early Bundled Payment Projects Test Positive”

- Modern Healthcare article published February 2014
- Brooks Rehabilitation in Jacksonville, Florida is a post-acute Model 3
- Has yielded lower costs and fewer hospital readmits
- 3 factors to Brooks Rehabilitations’ success:
  - Care navigators for entire episode of care
  - Analytics and information technology infrastructure development
  - Culture change
Employer-Driven Bundled Payment Initiatives

PepsiCo and Johns Hopkins Hospital Team-up

- Bundled payments for cardiac and orthopedic (joints) episodes
- 250,000 PepsiCo employees nationwide
  - Travel to Baltimore, Maryland for procedures
- Reduces costs by avoiding readmissions, limiting unnecessary procedures and diagnostic tests, and improving outcomes
- Greater ability to predict future healthcare costs
- Guaranteed hospital business
- Other employers are exploring direct payment bundling for episodes of care
Operational Infrastructure: What it Takes

Interdisciplinary Teams

- Developed internal work teams:
  - Patient identification and notice of admission
  - Care coordination
  - Quality and patient safety
  - Billing and claims
  - Cost savings
- Identify processes to be redesigned, accountabilities, gaps, and performance measurements
- Set performance standards
- Accountability

- Supply chain
- Physician oversight
- System oversight
- Documentation and coding
- Analytics
Co-Management Arrangements

What Are They?

- Mechanism by which a hospital and physicians jointly manage a service
- Typically focused on one clinical service line (e.g., orthopedics, cardiovascular)
- Engage physicians to achieve the following:
  - Greater operational/cost efficiencies
  - Improved patient care outcomes
Co-Management Structure

Hospital contracts with a physician organization, under which the physicians are granted input and managerial authority to design and enforce clinical and operational standards. Generally, the physicians provide only their time and no other personnel or items.
Physicians Are Involved In Each Aspect of Operations

Possible Co-Management Responsibilities

Financial and Operations
- Management oversight of staffing
- Negotiation of service arrangements
- Operating and capital budgets
- Length-of-stay management and patient throughput

Planning and Business Development
- Strategic plan development
- Technology planning
- Marketing strategies
- Clinical research plan

Quality of Care
- Development of care protocols
- Quality management and improvement policies
- Quality outcomes
- Patient experience

Co-management company governance structure includes various committees for managing all aspects of planning and care delivery (i.e., Quality Care Committee, Technology Committee, Operations Committee, Finance Committee, Research Committee)
**Value of a Clinical Co-Management Arrangement**

<table>
<thead>
<tr>
<th>For Participating Physicians</th>
<th>For Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Formal means to get action</td>
<td>- Improve clinical outcomes</td>
</tr>
<tr>
<td>- Compensation for managerial services</td>
<td>- Greater communications and interaction with physicians</td>
</tr>
<tr>
<td>- Improved operations can lead to improved physician productivity</td>
<td>- Optimize service delivery</td>
</tr>
<tr>
<td>- Improved outcomes can lead to greater personal satisfaction and greater market share</td>
<td>- Currently no regulatory uncertainty (i.e., Office of Inspector General, Internal Revenue Service, Medicare)</td>
</tr>
<tr>
<td>- Creates a framework for service line and physician practice succession planning</td>
<td>- Is a step towards building needed infrastructure in preparation for valued-based purchasing, ACO, bundled payments, and other healthcare reform measures</td>
</tr>
<tr>
<td>- Identification with a quality program</td>
<td></td>
</tr>
<tr>
<td>- Low capital requirements for participation and low investment risk</td>
<td></td>
</tr>
</tbody>
</table>
Performance Targets Align Incentives to Objectives

Example of Orthopedic Performance Targets

In addition to baseline compensation, co-management agreements provide incentives for quality of care and operational performance.

<table>
<thead>
<tr>
<th>Performance Standard</th>
<th>Percent Maximum Allocation of Total Incentive Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Service Incentive Compensation (&quot;QSIC&quot;)</td>
<td>64%</td>
</tr>
<tr>
<td>Post-Procedure Complication Rate</td>
<td>8%</td>
</tr>
<tr>
<td>SCIP Core Measure Compliance (Composite Scoring)</td>
<td>20%</td>
</tr>
<tr>
<td>Implant Demand Matching (Correct Utilization)</td>
<td>18%</td>
</tr>
<tr>
<td>Orthopedic Inpatient Patient Satisfaction Scores: Likelihood of Recommending Hospital (Mean Score)</td>
<td>18%</td>
</tr>
<tr>
<td>Operational Efficiency Incentive Compensation (&quot;OEIC&quot;)</td>
<td>30%</td>
</tr>
<tr>
<td>Case On-Time Starts (Team in Room)</td>
<td>10%</td>
</tr>
<tr>
<td>O.R. Block Schedule Utilization Compliance Score</td>
<td>10%</td>
</tr>
<tr>
<td>Room Turn Around Time (TAT)</td>
<td>10%</td>
</tr>
<tr>
<td>New Program Development Incentive Compensation (&quot;NPDIC&quot;)</td>
<td>6%</td>
</tr>
<tr>
<td>Development and Implementation of Business Plan(s) for Orthopedic Services/Program</td>
<td>3%</td>
</tr>
<tr>
<td>Comprehensive Protocol and Pathway Development and Standardization</td>
<td>3%</td>
</tr>
</tbody>
</table>

Total: 100%

Source: The Camden Group
Completing the Continuum: Developing Relationships with Post-Acute Care Providers
Partnerships with Post-Acute Care Providers are Critical to Reduce Readmissions

Medicare Patients are the Highest Volume Users of Post-Acute Care

Currently there are 47.6 million Medicare beneficiaries with an estimated 9,100 individuals added to the program each day.\(^1\)

Medicare Patients’ Use of Post-Acute Services Throughout an “Episode of Care” (\(^2\))

43% of Medicare Beneficiaries are Discharged from Acute Hospitals to Post-Acute Care

<table>
<thead>
<tr>
<th></th>
<th>Higher</th>
<th>Intensity of Service</th>
<th>Lower</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-Term Acute Care Hospitals</strong></td>
<td>2%</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Long-Term Acute Care Hospitals</strong></td>
<td></td>
<td>11%</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Rehab</strong></td>
<td>41%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facilities</strong></td>
<td>52%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Rehab</strong></td>
<td>9%</td>
<td></td>
<td>21%</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
<td></td>
<td>61%</td>
</tr>
</tbody>
</table>

\(^1\) Source: U.S. Census Projections
Reducing the Spend
Providers at Risk for Value-Based Payment Seek to Reduce the Spend Across the Acute/Post-Acute Care Continuum

Example: Daily Rates Across the Continuum for Medicare Fee-for-Service

<table>
<thead>
<tr>
<th>Service</th>
<th>Daily Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Hospital</td>
<td>$1,819/day</td>
</tr>
<tr>
<td>LTACH</td>
<td>$1,450/day</td>
</tr>
<tr>
<td>Inpatient Rehab Facility/Unit</td>
<td>$1,314/day</td>
</tr>
<tr>
<td>Skilled Nursing/TCU</td>
<td>$432/day</td>
</tr>
<tr>
<td>Home with Home Health</td>
<td>$190/day</td>
</tr>
</tbody>
</table>

Source: MedPAC 2013 Based on FY11 Data
Post-Acute Plays a Big Role in Cost

Another Medicare Fee-for-Service Example

Source: NEJM – 368; 16-18 April 2013
Key Questions

- How is your organization’s orthopedic service line managed?
- What is your organization’s physician alignment strategy for orthopedic services?
- Do you have a physician champion to partner with?
- How do you ensure orthopedic services is coordinated?
  - Do you use nurse navigators and advanced practice clinicians?
  - Do you have relationships with post-acute care providers?
- Who are your best partners to expand your service line offerings?
- What acute care model redesign steps must be taken to enhance the orthopedic care continuum?
- How can you extend care management resources to partners for seamless transitions in care?
- What are your barriers to success and potential solutions?
Ms. Sreenivasan is a senior manager with The Camden Group with more than ten years of healthcare experience. She specializes in strategic and service line business planning, facility planning, financial feasibility analyses, and medical staff planning and alignment on behalf of community hospitals, healthcare systems, academic medical centers, and physician medical groups. Ms. Sreenivasan has worked with clients analyzing current and potential markets and developing population-based healthcare strategies. She has completed many of the firm’s orthopedic service line assessments, and has helped our clients to identify creative solutions that optimize their service line care delivery models and achieve their market, financial, and quality goals.

Ms. Sreenivasan previously served as the Director of the Virginia Cardiac Network, LLC for Inova Fairfax Hospital located in Falls Church, Virginia. Her responsibilities included the development of strategic and operational business plans to optimize clinical quality and operational performance, as well as oversight for the implementation of new service offerings.

Prior to joining Inova Fairfax Hospital, Ms. Sreenivasan was a consultant for C-Change (formerly known as the National Dialogue on Cancer), a national cancer organization led by President George H. W. Bush and Mrs. Barbara Bush. While at C-Change, she worked with cancer leaders from the private, public, and nonprofit sectors to develop strategies that address and mitigate national cancer health disparities.

Ms. Sreenivasan received her master’s degree in health administration from Medical University of South Carolina with Honors, and her bachelor’s degree in accounting, business administration, and finance from the College of Charleston. She is a member of the American College of Healthcare Executives.
Contact Information

Danielle L. Sreenivasan, MHA
Senior Manager
3080 Bristol Street, Suite 150
Costa Mesa, CA 92626
310.320.3990 x 8208 - 714.775.7760 (F)
DSreenivasan@TheCamdenGroup.com